HCF

THE HOSPITALS CONTRIBUTION FUND OF AUSTRALIA LIMITED
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11 September 2008

Ms Joanne Palisi
Director
Adjudications Branch
Australian Competition and Consumer Commission
GPO Box 3131
Canberra ACT 2601

Dear Ms Palisi,

Sisters of Charity Health Service Limited A91099 for revocation and substitution of A30216 and A30219 – interested party consultation

Thank you for your letter of 14 August 2008 regarding the application by the Sisters of Charity Health Service Limited for revocation and substitution of authorisations granted by the Australian Competition and Consumer Commission (ACCC) in April 2004 that enabled a network of Catholic hospitals to collectively bargain with health funds. We appreciate the additional days provided to us to allow us to present our views.

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Our view is the inevitable consequence to consumers of Authorisation A91099 being approved will be increased health insurance premiums or higher out of pocket expenses with no guarantee of improved quality when services are delivered at Revenue Negotiation Network hospitals. Our reasons for drawing this conclusion are detailed in this submission.

Substantial Public Benefits

Data Sharing

The authorisations being sought apply to a national network of hospitals. A key element of the authorisation is, "members of the CNA Revenue Negotiation Network to agree that they will only contract with each funding organisation on the basis that the funding organisation consents to data sharing between members of CNA Revenue Negotiation Network". It is also stated in the submission that if health funds do not agree to the terms, conditions and prices of their contracts being made available to all members of the CNA Revenue Negotiation Network then the operation of the CNA will be 'imperilled'.

All hospitals have the ability to benchmark a range of information with other hospitals and do. Information relating to price can be de-identified and aggregated for all funds and then

applied to the agreed benchmarking model. Individual fund prices are not critical to this type of exercise. Further, simple price comparisons between different hospitals can be misleading as they may not take into account:

- PHI fund member demographics;
- Payment model differences;
- Health Fund product differences;
- Contract negotiation history;
- Differences in clinical practice between states and hospitals;
- Timing of contract renewal;
- Length of stay; and
- Case mix variations per fund.

The listed CNA hospitals do not currently negotiate as a 'CNA group' with HCF despite the representations made as part of the original 2004 ACCC application. Negotiations are conducted with the various organisations that manage individual hospitals or hospital groups (such as Little Company of Mary). However all CNA hospitals have requested the right to share contract prices, with these requests **always** raised during commercial negotiations.

The inevitable consequence of contract prices being made available to all hospitals is that hospitals will seek the highest national rate available across hospitals and across individual contracts. We believe that this is inflationary with no other general benefit accruing.

Non-price contract terms

The SCHS is seeking authorisation for members of the CNA Revenue Negotiation Network to require that non-price terms of revenue contracts be on terms agreed among members of the Revenue Negotiation Network.

There would be a significant financial risk to private health insurers should authorisation be granted for the CNA Revenue Negotiation Network to dictate non-price terms. This risk would be realised should the CNA's request for an extension to their current boycott powers also be approved. Non-price terms cover funding models, business rules, audit processes, payment terms and privacy and dispute clauses to name but a few. Costs to health funds associated with changes to non-price terms can be extraordinary and may include system changes, staff education and legal advice. Furthermore there would be no guarantee that the CNA would not make further changes as part of future negotiations.

Collective boycott of large health funds

Health funds have different profiles in each state. Funds such as HCF and HBF have greater than 20% membership in NSW and WA respectively whilst their market share in other states is relatively low. Neither fund is part of a collective negotiating group as suggested in the CNA application. Further due to the geographic nature of health fund membership a fund may have greater than 20% membership in a state and yet make up significantly less than 20% of the revenue of the CNA hospitals. Health funds are not privy to the relative contributions of all funds to a hospital's revenue.

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[redacted]

In these situations the privately insured consumer is disadvantaged. They are often placed in a position where they must choose between the important long term relationship with a health fund and that with the doctors and hospitals that provide their health care.

The CNA alleges that health funds "delay or walk away" from HPPA's. This is not the case as for both small and large agreements affected members suffer serious disadvantage. It is HCF's experience that hospitals delay negotiations with smaller funds as they are less important to the hospital and therefore not a priority.

The CNA has provided anecdotal advice and subjective statements to support their request for authorisation for collective boycott. If approval is given it will ultimately be the private health consumer who will be disadvantaged due to either higher premiums or limited access to their health care providers of choice. Should the collective boycott authorisation be approved and enacted by the NSW CNA hospitals, 20,000 HCF member hospital admissions would be affected with many in regional areas having limited access to the private hospital sector should they choose to remain HCF members.

It is not appropriate that the failure of an individual negotiation in NSW could affect HCF members in all CNA hospitals nationally.

Period of Authorisation

The private health industry is highly regulated and has experienced significant change over the past few years. It can be anticipated that it will remain dynamic into the future. In view of this we believe that a 10 year authorisation is inappropriately long. Should any of the authorisations be approved the time period should be short in order to limit any adverse consequences on consumers and the industry.

We would be pleased to provide any other information that the ACCC may require to assist its review. Please do not hesitate to contact myself [9290 0101] or Helen Eriksson (9290 0178) if you have any questions or comments.

Yours faithfully

Susan Hamilton
Manager, Hospital Benefits

Cc Chris Wallace
General Manager, Benefits Management